Family in Crisis

Keynote address by Dr Bruce Sparks MBBCh, MFGP

The theme of the third General Practice Congress is *"Family in Crisis"*. This concerns the family in its broadest sense from two person families to extended family systems with multiple generations; from communal families of non-parent adults to single parent families and those with gay parents.

Mary Howell in her book "Helping Ourselves" has described the characteristics of a family as joint occupaton of a household, with sharing of time and space; an exchange of unpaid services between family members; a commitment to stay together over time; and bonds of ritual tradition and family history.[2]

Dr Peter Cusins has very crisply defined the family as "a number of people who think they are a family and act like one.[3]

Dr Norris has defined a family as "an open system in a state of dynamic equilibrium. A system is a set of organised, interacting and interdependent components – the function of the components (in a family, people) can only be fully understood in terms of the function of the whole".[4]

For this system to function as an integrated system it must maintain itself in a state of equilibrium – each member of the family in equilibrium with the other members.

Should a change be introduced into one component of the family system then a reciprocal balancing change will occur in some or all of the other components.

Should the rules and patterns of behaviour of this family permit this secondary change to occur then equilibrium is once more established, possibly with readjusted rules and values.

For example, should a young woman wish to marry out of her family faith then, depending on the existing rules and value systems, one of two outcomes is possible.

If there is a reciprocal "giving-in" by the parents then equilibrium is once more established, but if there is a reciprocal counteraction then imbalance and a crisis is precipitated. Thus within this system there must be "give and take" to maintain balance.

A sign of a healthy family system is that *it can adapt to changes* – allowing space for resistance and time to make the transition.

Some changes occur through growth – the child learning to walk or an adolescent becoming an adult. Other changes occur voluntarily : such as a change in occupation or a move to another city.

The changes most likely to produce non-equilibrium and crises are apparent negative ones such as death, sickness, depression or retrenchment which bring painful loss in the short term but from which we may learn and grow in the long term.

The families of the world have faced crises since Adam was given a wife and ate the apple - and we will face them until the ultimate or doomsday. It is a way of life, in fact the world has been described as a large family – we are always fighting and attempting to control one another.

The four horsemen of the apocalypse[7] death, famine, war and pestilence are ever present in our world today – eating at the very hearts of our families.

At home we have the unbalancing of family equilibrium by the pestilence of polio in Gazankulu, the cholera in Kwazulu, and the deaths of our young men on the borders of our country and South West Africa.

What of the dislocation of family units by the system of migrant labour and the pass laws, the hunger of the aged and less privileged associated with inflation and unemployment?

We must not neglect to consider the physically ill and crippled, the wife beaten in Bryanston, the child abuse in Hillbrow, the alcoholic or attempted suicide victim of Arcadia.

Surely we, the General Practitioners, are the only common denominator for assistance in crises of this type? Surely we, as Family Physicians are the only medical specialists expected to cope with the psychological, physical and spiritual implications which these families have to face. This is because of the uniqueness of the commitment the family doctor has to his patients.

- it is a commitment to the person and his family, regardless of age, sex, or type of problem;
- it is a commitment to the family as a unit by providing primary and continuing care with the realisation of the importance of inter-personal relationships within that unit;
- it is a commitment not terminated by resolution of the problem, or by referral, or by failure of therapy. The relationship of the family doctor with his patients and their families transcends individual episodes of illness and even death.

Unfortunately we have not been trained to counsel. We learn by trial and error – often only learning that we know less. Will Durant the American author and lecturer said: "Sixty years ago I knew everything; now I know nothing; education is a progressive discovery of our own ignorance".

Our medical school curriculum does not cater adequately for the total treatment of the person, only the disease. Up to now only lip service has been paid to an understanding of the concepts of interpersonal relationships. psychodynamics and the human behavioural sciences. It has

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been said that "to change a medical curriculum is like moving all the graveyards in England".

We as GPs must begin digging with every spade and shovel to fight for the right to determine our own curriculum, compulsory vocational training programmes and registerable speciality.

How should we counsel?

Perhaps we as doctors could begin by assessing our own families and what is happening within our own systems. We could start today by asking ourselves:

- what is the quality of the day for my family and its members?
- who feels supported, cared for, in control?
- who feels put upon, intruded on, out of control, neglected?
- what are the sorrows – are they necessary, could they have been avoided, can they be dealt with in a growth promoting manner?
- what are the joys – are they noticed, savoured, celebrated, can they be repeated or increased?
- what can we predict about the outcome of days like this?
- how is each member being shaped by living through this process of family function?[8]

We may then realise that we as doctors are possibly living on the very brink of a crisis within our own families. Doctors' families are known to be more vulnerable to crises of certain types, both physical and psychological.

"We learn by trial and error - often only learning that we know less"

Frequently we read that doctors have higher suicide, divorce, drug and alcohol abuse rates than an equivalent non-medical population. The majority of statistics arise from studies conducted in the USA and UK. It is impossible to obtain figures for South African doctors.

Doctors are as a rule abysmally poor patients. Although 90% of doctors in one survey said they recommended annual physical examinations only 30% practised what they preached. Another study compared the results of physical examinations in well physicians and dentists with a comparable group of executives.[9] Of 69 physicians and dentists, 45%, a substanitally higher number then in the executives, had significant asymptomatic problems, including eight with cardiovascular disease and two with malignancies.

Study of a group of doctors with diagnosed malignancies indicated that most had ignored such symptoms as bloody stools, recurrent abdominal cramps, jaundice, dysphagia, and haemopthysis for an average of 3 to 14 months. Another report showed that intelligent practitioners with myocardial infarctions waited twice as long from the outset of symptoms to seek medical help as did laymen.

Most persons waited an average of six hours, while the doctors waited 12 hours.

How many male doctors have had a PR to check for prostatic or ano-rectal carcinoma?

The following true story illustrates most poignantly our own psychological vulnerability.

One evening in 1808 a gaunt, sad-faced man entered the offices of Dr James Hamilton in Manchester, England. The doctor was struck by the melancholy appearance of his visitor, He inquired:

"Are you sick?"

"Yes doctor, sick of a mortal malady".

"What malady?"

"I am frightened of the terror of the world around me. I am depressed by life. I can find no happiness anywhere, nothing amuses me and I have nothing to live for. If you can't help me, I shall kill myself".

"The malady is not mortal. You only need to get out of yourself. You need to laugh; to get some pleasure from life".

"What shall I do?"

"Go to the circus tonight to see Grimaldi, the clown. Grimaldi is the funniest man alive. He'll cure you."

A spasm of pain crossed the poor man's face as he said: "Doctor don't jest with me: I am Grimaldi."

Three symptoms suggestive of psychological vulnerability are frequently seen in doctors. They are: bad marriages, drug abuse and the tendency to use psychotherapy. These have often been listed as the psychological hazards of medical practice.

Poor marriage can be blamed on long hours, lonely wives and demands of patients. The ready access to drugs could account of drug addiction, and the fact that doctors are heavy users of psychotherapy could be attributed to the fact that doctors are less self concious about seeking his avenue of help than non-professionals.

A study by Vaillant et at[10] has shown that these generalisations cited above are not accurate. In fact the study showed that the doctor most likely to develop the problems was one who had a barren unhappy childhood.

Suicide rates among male physicians are higher than the overall male population, while female doctors have a three times greater rate than the overall rate for women. These tendencies extend into practically every health-related area! eg doctor pilots are involved in fatal light plane crashes at a rate of four times that of all civilian non-commercial pilots.

What of the doctor's family, in particular his wife; is she more liable to face crises than other wives?; Again figures for South Africa are unavailable. Personal enquiry from psychologists and psychiatrists in Johannesburg have indicated that "many" doctor's wives (and doctors) attend their clinics as patients.

"Suicide rates among male doctors are higher than the overall male population"

Suicides are also more common in doctor's wives, possibly through easy access to drugs - or is it more a depressive illness due to loneliness, feelings of emotional displacement by the busy doctor's wife to attain her own full potential while he is pushed on by a host of admiring patients who further inflate his fantasy of omnipotence and of being the greatest physician since Hippocrates.

You may be interested to hear this list compiled in 1969 of the ten most serious complaints by husbands regarding their wives.[11]

1. Nags me; 2. Not affectionate; 3. Selfish - inconsiderate; 4. Complains too much; 5. Interferes with my hobbies; 6. Slovenly in appearance; 7. Quick tempered; 8. Interferes with my discipline; 9. Conceited; 10. Insecure.

The wives complain about their husbands being:

1. Selfish and inconsiderate; 2. Unsuccessful in business; 3. Untruthful; 4. Complains too much; 5. Doesn't show his affection; 6. Doesn't talk things over; 7. Harsh with children; 8. Touchy; 9. No interest in children; 10. Not interested in home.

Surely the basis for such complaints is that much bandied expression, "lack of communication". Communication is not just a matter of talking but rather it is an honest sharing of feelings, of friendship and a genuine desire to see things from the other's point of view.

All too often, however, a husband and wife simply take it for granted that each

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